

PLEASE WRITE PLAINLY, WITH UNFADING INK: Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

1142 09356

Reg. Dist. No. 265

## 1. PLACE OF DEATH:

County SomersetCity or town Lanfield  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County SomersetCity or town Lanfield  
(If outside city or town limits, write RURAL and give nearest town)Street No. 3319  
(If rural, give LOCATION)2.(a) If veteran, name war Wood Waves 1

## 3. (a) FULL NAME

Daniel Webster Adams

## 3. (b) Social Security Number

212-12-3113

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife

Selma M

7. Birth date of deceased (mo., day, yr.)

November 9, 1898

6. (c) If alive, give age ..... years

8. AGE:

Years

Months

Days

If less than one day

481026

hrs.

min.

9. Birthplace

Somerset, MD  
(Town, county, and state)

10. Usual occupation

Carpet

11. Industry or business

Booth, Steel Inc., Balto

12. Name

Eugene Adams

13. Birthplace

MD

14. Maiden name

Laura Haley

15. Birthplace

MD

16. Informant

Selma M Adams

Address

Lanfield, MD

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Oct 8, 1947  
(month) (day) (year)

Cemetery or crematory

Burial Ridge

Location

Lanfield, MD

18. Funeral director

David J. Livingston

Address

306 Main St. Lanfield, MD

19. Date rec'd by registrar

Oct 13, 1947

Registrar

Janice Espino

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 5 - 1947, at 2 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct. 5 - 9 AM 1947 to Oct. 5 - 2 PM 1947and that I last saw him alive on Oct. 5 - 1947

Immediate cause of death

DURATION

Pulmonary Fibrosis  
with Acute bz.  
compensation

Due to

Due to

Other conditions

Hypertension

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE

B E Keallum

M. D. or other

Address

LanfieldDate signed Oct 6-47

RECEIVED  
OCT 15 1947  
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The coroner is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

09357

## CERTIFICATE OF DEATH

Reg. Dist. No. 260

## 1. PLACE OF DEATH:

County Somerset  
 City or town Westover  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 76 yrs. 10 mos.  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Somerset  
 City or town Westover  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Mary Anne Ballard

## 3. (b) Social Security Number

4. Sex Fe 5. Color or race Col. 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Harve Ballard  
 6. (c) If alive, give age 88 years  
 7. Birth date of deceased (mo., day, yr.) Dec. 11, 1870

8. AGE: Years 76 Months 10 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Somerset Cottage Grove, Md.  
 (Town, county, and state)

10. Usual occupation Seafood

## 11. Industry or business

12. Name William Ballard  
 13. Birthplace Cottage Grove Md.  
 14. Maiden name Marriah Ballard  
 15. Birthplace Cottage Grove, Md.

16. Informant Annie Thompson  
 Address 2416 N. 2nd St. Chester, Pa.

17. Burial Burial Date thereof Oct. 14, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Cottage Grove  
 Location Col. Westover, Md.

18. Funeral director Charles H. Hard.  
 Address Marion Sta. Md.

19. 10/14/47 R. H. Johnson 7d. Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 11 1947 at 7:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1943 to Oct 11 1947  
 and that I last saw her alive on October 11 1947

Immediate cause of death

Diabetes mellitus

DURATION

10 years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury

Injured at work?

23. SIGNATURE

George G. Mausman  
 M. D. or other \_\_\_\_\_  
 Address D. Princess Anne, Md. Date signed 10.13.47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 265

## 1. PLACE OF DEATH:

County SomersetCity or town Longfield  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

MS Gready Memorial HospHow long in hospital or institution? 18 mo

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County SomersetCity or town Longfield  
(If outside city or town limits, write RURAL and give nearest town)Street No. Main St  
(If rural, give LOCATION)2(a) If veteran, name war None

## 3. (a) FULL NAME

Guy Louisbourg Lockman

## 3. (b) Social Security Number

None4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow8. (b) Name of husband or wife Arthur B. Lockman7. Birth date of deceased (mo., day, yr.) February 15, 18718. AGE: Years 76 Months 7 Days 27 If less than one day  
.....hrs. ....min.9. Birthplace Maine Station MD  
(Town, county, and state)10. Usual occupation Home owner11. Industry or business None12. Name Joseph Louisbourg13. Birthplace MD14. Maiden name Mary Beach15. Birthplace MD18. Informant Mrs. Helen SterlingAddress Main St, Longfield MD17. Burial Date thereof Oct 14, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Burial RidgeLocation Longfield, MD18. Funeral director Deceased & SonAddress 306 Main St, Longfield19. Oct 14 19 47 Janice E. Spino  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 12 19 47 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 1 19 46 to Oct 12 19 47and that I last saw live on Oct 12 19 47Immediate cause of death Cerebral hemorrhageand old heartDURATION 5 daysDue to Cerebral hemorrhageCerebral myositisDue to Arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Guy L. Lockman MDAddress Main St MD Date signed Oct 14-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH: Somerset  
 County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death.....  
 Hospital, institution, or street address where death occurred:  
 Rural, at home  
 How long in hospital or institution? //

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... Maryland County..... Somerset  
 City or town..... Rural, Kingston  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... Rural  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

3. (a) FULL NAME  
 Medora Turpin Dashiell

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife A. T. Dashiell  
 7. Birth date of deceased (mo., day, yr.) February 13, 1882  
 6.(c) If alive, give age 61 years

8. AGE: Years 65 Months 7 Days 23 It less than one day  
 hrs. min.

9. Birthplace..... Kingston-Somerset-Md.  
 (Town, county, and state)

10. Usual occupation..... Postmistress

11. Industry or business..... Post Office

12. Name..... Alfred B. Turpin

13. Birthplace..... Kingston, Md.

14. Maiden name..... Elizabeth Bell

15. Birthplace..... Crisfield, Md.

16. Informant..... A. T. Dashiell

Address..... Kingston, Md.

17. Burial Date thereof Oct 8, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Episcopal Cemetery

Location..... Princess Anne, Md.

18. Funeral director..... H. Harvey Bradshaw

Address..... Crisfield, Md.

19. Oct 10, 1947. Nellie Dryden  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... October 6, 1947 at 9:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1, 1947 to Oct. 6, 1947 and that I last saw her alive on Oct. 5, 1947

Immediate cause of death..... acute dilation of heart  
 Chronic myocarditis Chronic nephritis  
 Due to..... to

Due to..... to

Other conditions..... carcinoma of Breast  
 + metastasis in lung + bones  
 (Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

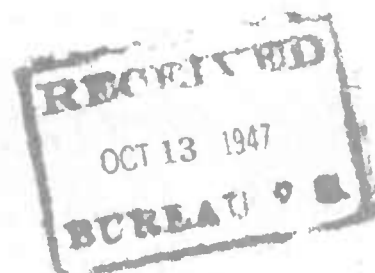
Means of injury..... Injured at work?.....

23. SIGNATURE..... Guy B. Boellman M.D.  
 Address..... marion, Md. Date signed..... Oct. 10, 1947

Address.....

Date signed.....







# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09359

Reg. Dist. No. 265

### 1. PLACE OF DEATH:

County Somerset

City or town marion  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Somerset

City or town marion Rural  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Edward Thos. Davis

### 3. (b) Social Security Number

215-20-0061

#### 4. Sex

male

#### 5. Color or race

white

#### 6. (a) Single, married, widowed, or divorced

married

#### 6. (b) Name of husband or wife

Eleanor Davis

6. (c) If alive, give age 54 years

#### 7. Birth date of deceased (mo., day, yr.)

June 15, 1891

#### 8. AGE:

Years 56

Months 2

Days 19

If less than one day

hrs. \_\_\_\_\_

min. \_\_\_\_\_

#### 9. Birthplace

Accomac Co. Virginia  
(Town, county, and state)

#### 10. Usual occupation

Laborer

#### 11. Industry or business

Farm Work

#### 12. Name

Henry Davis

#### 13. Birthplace

Virginia

#### 14. Maiden name

Arrie Zimmell

#### 15. Birthplace

E. Virginia

#### 16. Informant

Mrs. Davis

#### Address

marion, md.

#### 17. (Burial, cremation, or removal. Which?)

Burial

#### Date thereof

10/7/47  
(month) (day) (year)

#### Cemetery or crematory

Overgreen

#### Location

Berlin, Md.

#### 18. Funeral director

Anna D. Burbage

#### Address

Berlin, Md.

#### 19. (Date rec'd by registrar)

Oct. 13

19 47

Janice E. Spines

Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH October 4, 1947, at 10:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

September 27, 1947, to October 4, 1947

and that I last saw him alive on October 1st, 1947

#### Immediate cause of death

Acute Dilatation of Heart

#### DURATION

Sept. 27

1947

to

Oct 4

1947

#### Due to

Chronic myocarditis

#### Due to

Chronic Int. Nephritis

#### Other conditions

(Include pregnancy within 8 months of death)

#### Major findings of operations

none

Date of op. \_\_\_\_\_

#### Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

#### 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. \_\_\_\_\_ Date of \_\_\_\_\_

#### Where did injury occur?

(City or town)

(County)

(State)

#### Injured at home, farm, industry, public place (where?)

#### Means of injury

#### Injured at work?

#### 23. SIGNATURE

George C. Coulburn M.D.

M. D. or other \_\_\_\_\_

Address marion, md. Date signed Oct 4 1947

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
OCT 15 1947  
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 261

1. PLACE OF DEATH: *Marion Md.*  
 County.....  
 City or town.....*Rural*  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? *all life*  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State *Maryland* County *Somerset*  
 City or town *Marion* *Rural*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

3. (a) FULL NAME *Charles Henry Fontaine* 3. (b) Social Security Number

4. Sex *Male* 5. Color or race *C* 6. (a) Single, married, widowed, or divorced *Married*  
 6. (b) Name of husband or wife *Lillie Fontaine*  
*Somerset C* 6. (c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.) *Dec 24 - 1890*

8. AGE: Years *56* Months *0* 3 Days *24* If less than one day  
 .....hrs. ....min.

9. Birthplace *Somerset C*  
 (Town, county, and state)

10. Usual occupation *General work*

11. Industry or business

12. Name *Robert Fontaine*

13. Birthplace *Fannie Fontaine*

14. Maiden name *not known*

15. Birthplace

16. Informant *Lillie Fontaine*

Address *Marion Md.*

17. *Burial* Date thereof *Oct. 29, 1947*  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *Church Cemetery*

Location *Jamestown, Md.*

18. Funeral director *George W. Zilghman*

Address *Marion, Md.*

19. *Oct. 27* 19 *47* *Hollie Dryden*  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH *October 27th* 19 *47* at *11:00 A* M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *at intervals August* 19 *47* to *October 27* 19 *47*  
 and that I last saw him alive on *October 26* 19 *47*

Immediate cause of death *Acute dilatation of heart - coronary occlusion*  
*Ischemic myocarditis*  
*Chronic Nephritis*  
*& General Arteriosclerosis*

## DURATION

24 hrs

Due to.....  
 Due to.....  
 Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....  
 .....Date of op. ....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE *George B. Bullum* M. D. or other

Address *Marion, Md.* Date signed *Oct 27, 1947*

CRIMINAL CASE OF DEATH

STATE OF WASHINGTON

STATE OF WASHINGTON

STATE OF WASHINGTON

RECEIVED  
NOV 1 1947  
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

09361

## CERTIFICATE OF DEATH

Reg. Dist. No. 265

## 1. PLACE OF DEATH:

County SomersetCity or town Crisfield  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

M<sup>c</sup>Creedy Memorial Hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SomersetCity or town Princess Anne  
(If outside city or town limits, write RURAL and give nearest town)Street No. 518 Hampton Dr.  
(If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

Lula Harrison

## 3. (b) Social Security Number

Fontaine

4. Sex

Female

5. Color or race

Col.

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Isaac Henry Fontaine

7. Birth date of

deceased (mo., day, yr.)

January 1<sup>st</sup> 1889

6. (c) If alive, give age years

8. AGE:

58 Years9 Months13 Days

If less than one day

hrs.

min.

9. Birthplace

Cottage Grove, Maryland  
(Town, county, and state)

10. Usual occupation

Domestic

11. Industry or business

Home

FATHER

12. Name

George Ballard

MOTHER

13. Birthplace

Somerset Co., Md.

14. Maiden name

Florence Strugis

15. Birthplace

Somerset County, Md.

16. Informant

Isaac Fontaine

Address

Hampton Dr., Princess Anne, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Oct 20, 1947  
(month) (day) (year)

Cemetery or crematory

House of Jacob

Location

Chance, Maryland

18. Funeral director

J. Edgar Thomas

Address

Accomac, Virginia

19. Oct. 18

(Date rec'd by registrar)

19 47

Janice E. Spies  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 14, 1947 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

September 15, 1947 to October 14, 1947and that I last saw him alive on October 13, 1947

Immediate cause of death

Acute dilation of heart  
with partial coronary occlusion

DURATION

Due to

Chronic Int Nephritis,  
Chronic myocarditis  
& diabetes mellitus

Other conditions

General arteriosclerosis  
(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Sam E. Coulthart M.D.  
M. D. or other

Address

Manoi, Md.Date signed 10/15/47

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED - BUREAU OF VITAL STATISTICS

RECEIVED - BUREAU OF VITAL STATISTICS

RECEIVED  
OCT 20 1947  
BUREAU OF VITAL STATISTICS



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09362

Reg. Dist. No. 262

1. PLACE OF DEATH: Somerset  
 County.....  
 City or town..... Westover, R. F. D.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....  
 Hospital, institution, or street address where death occurred:  
 Route 13. Westover, R. F. D.  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... Maryland..... County..... Somerset  
 City or town..... Westover, R. F. D.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Juliania Grunhold

## 3. (b) Social Security Number

4. Sex..... Female  
 5. Color or race..... White  
 6.(a) Single, married, widowed, or divorced..... Widow  
 6.(b) Name of husband or wife..... \*\*\*\* William Grunhold  
 6.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.)..... September 21. 1862  
 8. AGE: Years..... 85 Months..... 0 Days..... 13 If less than one day..... hrs. .... min.  
 9. Birthplace..... Bordonia N. Y.  
 (Town, county, and state)  
 10. Usual occupation..... House Wife  
 11. Industry or business.....  
 12. Name..... Martin Krioll  
 13. Birthplace..... Germany  
 14. Maiden name..... Mary Dehn  
 15. Birthplace..... Germany

16. Informant..... Mr William Grunhold, Son  
 Address..... Westover, Somerset Co, R. F. D.  
 17. Burial..... Date thereof..... 10/7/1947  
 (Burial, cremation, or removal. Which?)..... (month) (day) (year)  
 Cemetery or crematory..... Manokin Prebyterian Cemetery  
 Location..... Princess Anne, Somerset Co, Md.  
 18. Funeral director..... Howard A. Gill  
 Address..... Pocomoke City, Maryland  
 19. Oct 6 1947 Mrs Clayton Davis  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH..... October 4. 1947 at 5PM M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19....., to..... 19.....  
 and that I last saw h..... alive on..... 19.....

Immediate cause of death.....  
 DURATION.....  
 Due to.....  
 Due to.....  
 Other conditions.....  
 (Include pregnancy within 8 months of death)

Major findings of operations.....  
 Date of op.....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?).....  
 Means of Injury..... Injured at work?

23. SIGNATURE.....  
 M. D. or other.....  
 Address..... Date signed 10/6-47



RECEIVED

OCT 8 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09363  
Reg. Dist. No. 265

## 1. PLACE OF DEATH:

County Somerset  
City or town Crisfield  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 75 years  
Hospital, institution, or street address where death occurred:  
3 Hudson St.  
How long in hospital or institution? ////////

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Somerset  
City or town Crisfield  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 3 Hudson Street  
(If rural, give LOCATION)  
2.(a) If veteran, name war ////////

## 3. (a) FULL NAME

Betty Hoffman

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife David W. Hoffman

7. Birth date of deceased (mo., day, yr.) Sept 7, 1853 6. (c) If alive, give age 75 years

8. AGE: Years 94 Months 1 Days 4 If less than one day hrs. min.

9. Birthplace Hacks Neck-Accomac-Va.  
(Town, county, and state)

10. Usual occupation Housewife11. Industry or business Home12. Name Unknown13. Birthplace Unknown14. Maiden name Mary Ward15. Birthplace Northampton Co., Va.16. Informant Mrs. Agnes HoffmanAddress Crisfield, Md.

17. Date thereof Oct 13, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Crisfield CemeteryLocation Crisfield, Md.18. Funeral director H. Harvey BradshawAddress Crisfield, Md.

19. Oct. 25 47 Janice E. Spier  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 11 19 47, at 12:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 7 19 47, to Oct 11 19 47.

and that I last saw him alive on Oct 11 19 47.

Immediate cause of death Heart Block DURATION ?

(Adams-Stokes Syndrome)

Due to Arteriosclerosis ?

Due to Arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underwrite the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE S. M. Peyton M.D.  
M. D. or other

Address Crisfield, Md. Date signed Oct 14

RECEIVED  
OCT 27 1947  
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09364

Reg. Dist. No. 21621

## 1. PLACE OF DEATH:

County Somerset  
 City or town Rural West Over Md  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 yearsHospital, institution, or street address where death occurred: ✓How long in hospital or institution? ✓

## 3. (a) FULL NAME

John Mason Jones

## 4. Sex

Male

## 5. Color or race

Color

## 6. (a) Single, married, widowed, or divorced

Single6. (b) Name of husband or wife: ✓6. (c) If alive, give age. ✓ years7. Birth date of deceased (mo., day, yr.) November 16-1910

## 8. AGE:

Years

Months

Days

If less than one day

36119

hrs.

min.

## 9. Birthplace:

Virginia  
(Town, county, and state)

## 10. Usual occupation:

None11. Industry or business: ✓

FATHER  
MOTHER

## 12. Name:

## 13. Birthplace:

## 14. Maiden name:

## 15. Birthplace:

## 16. Informant:

## Address:

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof:

(month) (day) (year)

## Cemetery or crematory:

## Location:

## 18. Funeral director:

## Address:

## 19. Oct 27

(Date rec'd by registrar)

19 47

Mrs Clayton Davis

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SomersetCity or town Rural West Over Md  
(If outside city or town limits, write RURAL and give nearest town)Street No. ✓

(If rural, give LOCATION)

2. (a) If veteran, name war: ✓

## 3. (b) Social Security Number

✓

## MEDICAL CERTIFICATION

20. DATE OF DEATH: October 25 19 47 330A21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 21 19 47 to Oct 25 19 47and that I last saw him alive on Oct 23 19 47Immediate cause of death: Pulmonary tuberculosis

DURATION

Due to: General ArthritisDue to: Local Infected Teeth TonsilsOther conditions: ✓

(Include pregnancy within 8 months of death)

Major findings of operations: ✓Date of op. ✓Autopsy results: ✓

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ✓ Date of ✓

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Eleanor G. Maverman

M. D. or other

Address: Prin Anne mdDate signed: 10 27 47

RECEIVED

OCT 29 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

09365

265

## 1. PLACE OF DEATH:

County..... Somerset

City or town..... Crisfield  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

Walter R. Hanson

4. Sex..... Female

5. Color or race..... White

6. (a) Single, married, widowed, or divorced..... Married

6. (b) Name of husband or wife..... John H. Hanson

6. (c) If alive, give age..... 66 years

7. Birth date of deceased (mo., day, yr.)..... January 31, 1879

8. AGE: Years..... 68 Months..... 8 Days..... 18 If less than one day..... hrs. .... min.

9. Birthplace..... Crisfield, Md.  
(town, county, and state)

10. Usual occupation..... Operator

11. Industry or business..... B. K. W. Co.

12. Name..... James C. Sterling

13. Birthplace..... Crisfield, Md.

14. Maiden name..... Sue Hughes

15. Birthplace..... Va

16. Informant..... John H. Hanson

Address..... Crisfield, Md.

17. (Burial, cremation, or removal. Which?)..... Burial Date thereof..... Oct 21, 1947  
(month) (day) (year)

Cemetery or crematory..... Sunny Ridge

Location..... Crisfield, Md.

18. Funeral director..... Hubbard B. Cunningham

Address..... Crisfield, Md.

19. Oct. 27 1947 (Date rec'd by registrar)

James E. Spies Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md County..... Somerset

City or town..... Crisfield  
(If outside city or town limits, write RURAL and give nearest town)Street No..... Crisfield Ave  
(If rural, give LOCATION)

2. (a) If veteran, name war..... None

## 3. (b) Social Security Number

212-00-5283

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... October 19 1947 at 4:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 15 1947 to Oct 19 1947.

and that I last saw him alive on..... 19.....

Immediate cause of death..... Tuberculous pneumonia

Pulmonary congestion

and pleural effusion

Due to..... Pulmonary tuberculosis

Due to.....

Other conditions..... Malnutrition

(Include pregnancy within 3 months of death)

Major findings of operation..... None

Date of op.....

Autopsy results..... None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... C. G. Ranley M.D.

Address..... Crisfield, Md. Date signed..... 10/20/47

RECEIVED  
NOV 1 1947  
BUREAU OF



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 760

## 1. PLACE OF DEATH:

County Somerset  
 City or town Oriole  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Somerset  
 City or town Oriole  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

George R. Maddox

## 3. (b) Social Security Number

None4. Sex M. 5. Color or race Col. 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Mary Maddox6. (c) If alive, give age 78 years7. Birth date of deceased (mo., day, yr.) Sept. 14, 18948. AGE: Years 73 Months \_\_\_\_\_ Days \_\_\_\_\_ It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Oriole, Somerset, Md.  
(Town, county, and state)10. Usual occupation Seaford

11. Industry or business \_\_\_\_\_

12. Name Littleton Maddox13. Birthplace Oriole, Maryland14. Maiden name Unknown15. Birthplace Unknown16. Informant Nermetta BradshawAddress Nanticoke, Md.17. Burial Oct. 12, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. JamesLocation Oriole, Md.18. Funeral director Charles H. FordAddress Marion St., Md.19. 10/11 47 R. E. Johnson, Jr.  
(Date rec'd by registrar) (month) (day) (year) Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH October 10 1947, at 10 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 25 1947, to Oct 1 1947and that I last saw him alive on Oct 1 1947Immediate cause of death Carcinomaof StomachDURATION 2 years

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

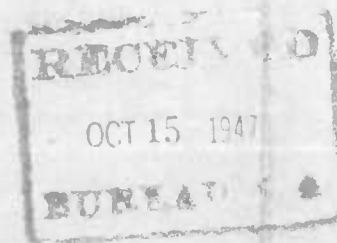
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Frank Matus M. D. or other \_\_\_\_\_Address Princess Anne Date signed 10/11/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131b

09367

## CERTIFICATE OF DEATH

Reg. Dist. No. 261

## 1. PLACE OF DEATH:

County Somerset  
 City or town Rural, Kingston, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 29 years  
 Hospital, institution, or street address where death occurred:  
Rural, Kingston, Md.  
 How long in hospital or institution? 11111

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Somerset  
 City or town RURAL, Kingston  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Thomas Luther Marshall

## 3. (b) Social Security Number

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>
6. (b) Name of husband or wife <u>Flora Marshall</u>		
7. Birth date of deceased (mo., day, yr.) <u>March 18, 1881</u>		
8. AGE: Years <u>66</u> Months <u>7</u> Days <u>10</u> If less than one day _____ hrs. _____ min.		
6. (c) If alive, give age <u>66</u> years		

9. Birthplace Winston-Salem, N. C.  
 (Town, county, and state)  
 10. Usual occupation Farmer  
 11. Industry or business Agriculture  
 12. Name Thomas Marshall  
 13. Birthplace Winston-Salem, N. C.  
 14. Maiden name Elizabeth Haines  
 15. Birthplace Winston-Salem, N. C.  
 16. Informant Mrs. Mortimer Davis  
 Address Marion, Maryland

17. Burial Date thereof Oct. 30, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Rehobeth Presbyterian Cem.  
 Location Rehobeth, Maryland  
 18. Funeral director H. Harvey Bradshaw  
 Address Crisfield, Maryland

19. October 30, 1947  
 (Date rec'd by registrar) Nellie Syden  
 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 28, 1947 at 6:20 A. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 18, 1947 to October 28, 1947  
 and that I last saw him alive on October 20, 1947.

Immediate cause of death Cerebral hemorrhage, acute  
Chronic nephritis, General  
Arteriosclerosis  
 DUE TO Arteriosclerosis  
 DUE TO \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
 23. SIGNATURE Eng. A. Pullman M.D.  
 Address Monro St. Md. Date signed Oct 30, 1947

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NOV 8 1947

BUREAU

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50

69513

## CERTIFICATE OF DEATH

Reg. Dist. No. 265

## 1. PLACE OF DEATH:

County Somerset  
 City or town Crisfield  
 (If outside city or town limits, write RURAL and give nearest town)  
Lifetime  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
238 N. Somerset Ave.  
 How long in hospital or institution? //////

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Somerset  
 City or town Crisfield  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 238 N. Somerset Ave.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Nellie Jane Nelson

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife //////  
 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20, 1891

8. AGE: Years 56 Months 6 Days 29 If less than one day  
 ....hrs. ....min.

9. Birthplace Crisfield-Somerset-Md.  
 (Town, county, and state)

10. Usual occupation Schoolteacher

11. Industry or business Education

12. Name G. Thomas Nelson

13. Birthplace Crisfield, Md.

14. Maiden name Annie Laird

15. Birthplace Crisfield, Md.

16. Informant Mrs. Lena Hinman

Address Somerset Ave., Crisfield

17. Burial Date thereof Oct 21, 1947  
 (Burial, cremation, or removal Which?) (month) (day) (year)

Cemetery or crematory St. Peters Cemetery

Location Rural, Crisfield, Md.

18. Funeral director H. Harvey Bradshaw

Address Crisfield, Md.

19. Nov 10, 1947 Nellie Dryden  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 19, 1947 12 NOON

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1, 1946 to Oct 19, 1947

and that I last saw her alive on Oct 19, 1947

Immediate cause of death Acute Die? heart

Due to Cerebral Thrombosis - Heart. Mus. 2 years

Due to Spr. Pleur. & Rags

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Eugene C. Corbett M.D. M. D. or other

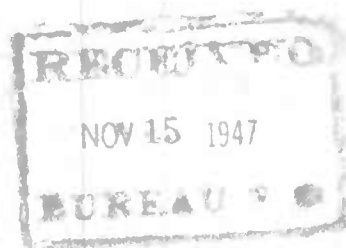
Address Marriott St. Cris Date signed Oct 21, 47

MARGIN RESERVED FOR BINDING

VS A15

9-45-11

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09368

Reg. Dist. No. 260

### 1. PLACE OF DEATH:

County Somerset  
City or town Princess Anne Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED

(For newborn infants give residence of mother)

State Md. County Somerset  
City or town Princess Anne, Md.  
(If outside city or town limits, write RURAL and give nearest town)

Street No. Route #1  
(If rural, give LOCATION)

2. (a) If veteran, name war

### 3. (a) FULL NAME

Donovan William Pasquith

### 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Martha Pasquith

6. (c) If alive, age 24 years

7. Birth date of deceased (mo., day, yr.)

July 23, 1913

8. AGE:

Years

Months

Days

If less than one day

34

hrs. min.

9. Birthplace

Princess Anne, Somerset, Md.  
(Town, county, and state)

10. Usual occupation

Carpenter

11. Industry or business

Building Carpenter

FATHER

12. Name

Henry Pasquith

13. Birthplace

Oriskany Md.

MOTHER

14. Maiden name

Katie M. Hastings

15. Birthplace

Oriskany, Md.

16. Informant

Mrs. Bessie Payer

Address

Princess Anne Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Oct 18, 1947  
(month) (day) (year)

Cemetery or crematory

Presbyterian Cemetery

Location

Princess Anne Md.

18. Funeral director

Dale Plachoff

Address

Princess Anne Md.

19. Oct. 17, 47

(Date rec'd by registrar)

R. S. Johnson, M.D.  
Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH October 16 1947 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 15 1947 to Oct. 15 1947

and that I last saw him alive on October 15 1947

Immediate cause of death Pulmonary

Tuberculosis

DURATION

10 years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank Matheus

M. D. or other

Address Princess Anne

Date signed 10/17

MARGIN RESERVED FOR BINDING

VS A15 9.43.15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

OCT 18 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

09369

## CERTIFICATE OF DEATH

Reg. Dist. No. 262

## 1. PLACE OF DEATH:

County... Somerset  
 City or town... Shelltown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Lifetime  
 Hospital, institution, or street address where death occurred:  
Rural  
 How long in hospital or institution? ////

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Somerset  
 City or town... Rural, Shelltown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Rural  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

James F. Powell

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Julia Powell  
 6. (c) If alive, give age 67 years  
 7. Birth date of deceased (mo., day, yr.) July 26, 1876  
 8. AGE: Years 71 Months 2 Days 12 If less than one day  
 ...hrs. ...min.

9. Birthplace Shelltown-Somerset-Md.  
 (Town, county, and state)  
 10. Usual occupation Retired Farmer  
 11. Industry or business Cattle-Poultry  
 12. Name John A. Powell  
 13. Birthplace Somerset Co., Md.  
 14. Maiden name Mary Riffin  
 15. Birthplace Somerset Co., Md.  
 16. Informant Mrs. Julia Powell  
 Address Shelltown, Md.  
 17. (Burial, cremation, or removal, Which?) Burial Date thereof Oct 10, 1947  
 (month) (day) (year)  
 Cemetery or crematory Rehobeth Baptist Cemetery  
 Location Rehobeth, Md.  
 18. Funeral director H. Harvey Bradshaw  
 Address Crisfield, Md.

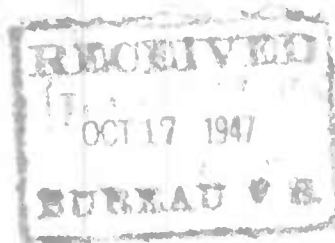
## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 8 19 47 at 10:30 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 47 to Oct 8 19 47  
 and that I last saw him alive on Oct 8 19 47  
 Immediate cause of death Arterio-sclerotic heart dis. DURATION 2 yrs.  
 Due to Senility + starvation 6 mo.  
 Due to  
 Other conditions  
 (Include pregnancy within 8 months of death)  
 Major findings of operations None. Date of op.  
 Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?  
 23. SIGNATURE Louis S. Clemens, M.D. M.D. or other  
 Address Pocomoke City, Md. Date signed 10-14-47

19. Oct 14 19 47 Mrs. Clayton Harris  
 (Date rec'd by registrar) Registrar



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09370

Reg. Dist. No. 260

## 1. PLACE OF DEATH:

County SomersetCity or town Coatsburg - Pr. Anne  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County SomersetCity or town Princess Anne  
(If outside city or town limits, write RURAL and give nearest town)Street No. Route #1  
(If rural, give LOCATION)

2.(a) if veteran, name war

## 3. (a) FULL NAME

Ida Ella Ruark

## 3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed6. (b) Name of husband or wife Henry Ruark

6. (c) If alive, give age. years

7. Birth date of deceased (mo., day, yr.) Jan 15, 18748. AGE: Years 73 Months 3 Days — If less than one day — hr. — min.9. Birthplace East Princess Anne, Somerset Md.  
(Town, county, and state)10. Usual occupation Housewife

## 11. Industry or business

12. Name William Jones13. Birthplace Princess Anne Md.14. Maiden name Ada Fleming15. Birthplace Princess Anne Md.16. Informant Mrs. Clifton PetersonAddress Princess Anne, Md.17. Buried Date thereof Oct 16, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Friendship cemeteryLocation East Princess Anne Md.18. Funeral director Wale BlackwellAddress Princess Anne, Md.19. Oct. 17 47 R. J. Johnson M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 14 19 47 at 6:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 15 19 47 to Oct 11 19 47and that I last saw her alive on Oct. 11 19 47Immediate cause of death Carcinomaof large colon

## DURATION

6 mo

Due to

Due to

Other conditions ArteriosclerosisHeart Disease

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Frank Waters M.D.

M. D. or other

Address Princess Anne Date signed Oct 16.

RECEIVED

OCT 18 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09371

Reg. Dist. No. 265

## 1. PLACE OF DEATH:

County Somerset  
 City or town Longfield  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? None  
 Hospital, institution, or street address where death occurred  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Somerset  
 City or town Longfield  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 33 Somerset Ave  
 (If rural, give LOCATION)  
 2(a) If veteran, name war None

## 3. (a) FULL NAME

Margaret L. Lawrence

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow  
 6. (b) Name of husband or wife James L.  
 7. Birth date of deceased (mo., day, yr.) August 10, 1864  
 8. AGE: Years 80 Months 1 Days 24 If less than one day  
 6. (c) If alive, give age \_\_\_\_\_ years

9. Birthplace Somerset, Va.  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Home12. Name Washington B. Croswell13. Birthplace Pugonia14. Maiden name Julia A. Potter15. Birthplace Somerset, Va.16. Informant Adeline PriceAddress Longfield, Md17. Burial Date thereof Oct 6, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory LongfieldLocation Longfield, Md18. Funeral director Wm. B. CroswellAddress 304 Main St, Longfield, Md19. Oct 7 19 47  
(Date rec'd by registrar)Registrar Janice E. Spino

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 4 19 47, at 10:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 2 19 47, to Oct 4 19 47and that I last saw her alive on Oct 4 19 47Immediate cause of death Coronary Thrombosis

## DURATION

2 daysDue to ArteriosclerosisDue to Hypertension

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE Samuel W. Payton M.D.

M. D. or other

Address Croswell Rd Date signed Oct 4, 1947

RECEIVED

OCT 9 1947

BUREAU OF



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09372

Reg. Dist. No. 268

## 1. PLACE OF DEATH:

County... Somerset  
 City or town... James Quarter Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 87 yrs  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution? -

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... MD County... Somerset  
 City or town... James Quarter (Rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No...  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war...

## 3. (a) FULL NAME

William Thomas White

## 3. (b) Social Security Number

4. Sex Male 5. Color or race Blk 6. (a) Single, married, widowed, or divorced Widower  
 6. (b) Name of husband or wife Deceased  
 6. (c) If alive, give age... years  
 7. Birth date of deceased (mo., day, yr.) Jan. 1860

8. AGE: Years 87 Months 9 Days - If less than one day - hrs. - min.

9. Birthplace James Quarter  
 (Town, county, and state) Waterman

10. Usual occupation Oystering

11. Industry or business Oystering

12. Name George White

13. Birthplace James Quarter Md

14. Maiden name Mary Groves Jones

15. Birthplace James Quarter Md

16. Informant Isaac White

Address James Quarter Md

17. (Burial, cremation, or removal. Which?) Burial Date thereof Oct 21 - 47

Cemetery or crematory James Quarter M.E. Ch.

Location James Quarter Md

18. Funeral director H. Webster

Address Deale Island Md

19. Oct-21 47 Lala S. Wheatly

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 19th 19 47 at 4 44 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 10th 19 47 to Oct 19 19 47 and that I last saw him alive on Oct 13th 19 47

Immediate cause of death Chronic myocarditis 2 yrs.

Due to -

Due to -

Other conditions -

(Include pregnancy within 3 months of death)

Major findings of operations -

Date of op. -

Autopsy results -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -

Means of injury - Injured at work? -

23. SIGNATURE Edore G. M. and son

Address Princess Anne Md M. D. or other -

Date signed Oct-20-47

